

Cross-national clinical exchange in child psychiatry across cultural contexts and mental health systems: a scoping review

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Abstract

BACKGROUND

Clinical practice in child and adolescent psychiatry (CAP) relies on internationally shared, empirically grounded guidelines, yet their application is influenced by socioeconomic and cultural differences. Cross-national clinical exchange allows health professionals to learn from similarities and differences. To map cross-national clinical exchange in CAP and summarise reported benefits, challenges, and impacts on clinical practice.

METHODS

This scoping review was conducted in line with the Joanna Briggs Institute methodology and reported in accordance with PRISMA-ScR guidelines. PubMed, PsycINFO and Web of Science were searched for publications between January 2015 and October 2025. Eligible records involved clinicians, trainees, or teams engaged in cross-national expertise exchange within CAP (0–18 years). Findings were synthesised thematically.

RESULTS

After deduplication, 1,944 records were identified. Twenty-one full text articles were assessed. Three studies were included from the United States, India and the Netherlands. Main themes show that exchange programmes result in awareness of differences and similarities; recognition of the interactions between clinical practice, culture, and mental health care services; and professional development.

CONCLUSIONS

Evidence is limited, but pilot programmes suggest cross-national exchanges increase awareness of culture and care system organisation shaping clinical practice. Further research should assess the added value, cost-effectiveness, and which formats work best for whom.

Preregistration

This review was preregistered on the Open Science Framework (OSF): <https://osf.io/pqm3t/>

Introduction

Professionals working in child and adolescent mental health (CAMH) services seek to provide high-quality mental health care for children and families across settings. Shared diagnostic classification frameworks, such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association (2013)) and the International Classification of Diseases, 11th Revision (ICD-11; World Health Organization (2022), together with evidence-based treatment guidelines and models of care, aim to support clinical work with consistency in communication and clinical practice (e.g., Setyawati et al. (2018)). International access to publications, international topic- or condition-specific communities of practice, and continuous education opportunities (e.g., scientific meetings) facilitate cross-national dialogue and learning (e.g. Palacio (2017)). However, the added value of on-the-job cross-national exchanges, in which professionals learn directly from routine clinical practice in another country, has received less attention. Such experiences may complement conventional training by supporting learning in clinical skills as well as leadership and health advocacy competencies (de Veen et al., 2018; Hodes et al., 2018; Rebowska, 2017; Tehrani et al., 2025).

Cross-national differences in clinical practice reflect interactions between culture, mental health care service provision systems, and routine clinical practice (Hwang et al., 2008). In this view, culture may not operate as a separate factor, but as a context that shapes both clinical reasoning and service organisation. At the same time, routine clinical practice and mental health care system structures can also reinforce or change relevant aspects of culture over time. In this paper, culture refers to such aspects including shared meanings, norms, and expectations that shape how distress is recognised, communicated, and interpreted in clinical encounters, as well as how help-seeking and responsibility for care are understood (Hwang et al., 2008). International variations in mental health care systems include reimbursement arrangements, referral pathways, educational structures, and access to services (Delamare & Ibeziako, 2013; Ronis et al., 2017). These conditions shape incentives and referral thresholds, influence access to specialist services and opportunities for specialised knowledge to develop. As a result, specialised expertise may be concentrated in some regions more than others (Albayrak et al., 2012). Clinicians therefore practice within locally shaped constraints and expectations, which can influence what problems present to mental health services and how mental health needs are interpreted and prioritised across settings. For cross-national exchanges, this means that observed differences may reflect both structural conditions (e.g., routines and service availability) and cultural norms and expectations that shape how care is organised and delivered.

Clinical exchange programmes hold promise to show participants that clinical practice is where cultural meanings interact with system constraints to shape everyday assessment, communication, and treatment routines. Exchanges may highlight that cultural influences can shape symptom recognition and presentation, and patient-clinician communication (Biswas et al., 2016; Compton & Shim, 2015; Kirmayer & Ryder, 2016; Manago, 2015; Meeuwesen et al., 2009). For example, if distress in a given cultural context is expressed more often through somatic complaints and care is understood as a shared family responsibility, this can shape problem formulation, diagnostic labelling, and treatment expectations in clinical encounters.

Despite potential benefits, cross-national clinical exchanges can be resource-intensive, requiring time and financial investment, and often involving travel-related emissions. As such, they are currently only available for a limited number of clinicians in CAMH services. Moreover, it remains unclear how, if at all, such clinical exchange programmes can affect participants' clinical skills and professional development. Hence, a scoping review is warranted to map the existing literature, summarise reported impacts, and identify evidence gaps. Accordingly, this review explores the literature on cross-national clinical exchange in child and adolescent psychiatry (CAP). Specifically, this review aims to (1) map the literature on cross-national clinical exchange in CAP, (2) summarise reported impacts on clinical skills and professional development, and (3) identify evidence gaps and priorities for future research.

Methods

Methods followed the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis (Munn et al., 2019); reporting was informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guideline (Tricco et al., 2018). Objectives, inclusion criteria, and methods were prespecified in a protocol and preregistered on the Open Science Framework (OSF): <https://osf.io/pqm3t/>. No amendments were made to the preregistered protocol after it was submitted to the OSF. The preregistered JBI protocol is provided in Supplementary Appendix S1. Completed PRISMA 2020 checklists for the abstract and full manuscript are provided in Supplementary Checklists S1 and S2.

Search strategy

Sources included MEDLINE (via PubMed), PsycINFO and Web of Science for 2015-2025 (last searched: October 16, 2025). The search was limited to 2015–2025 to focus on contemporary exchange practices and current care contexts, and to ensure feasibility of screening. Gray literature (e.g., theses, conference abstracts, policy documents, and preprints) was searched via Google Scholar. The search strategy was developed with an information specialist and peer-reviewed before execution. Searches combined standardised terms (e.g., MeSH) and free-text keywords, with limits to English and

publication years, and were adapted per database. The database search identified the following number of records: PubMed (n = 708), PsycINFO (n = 585), Web of Science (n = 951). Full search strategies are provided in Supplementary Appendix S2.

A three-step strategy was used: (1) a preliminary scoping search in MEDLINE (via PubMed) to identify key terminology from titles/abstracts and indexing. (2) application of the finalised strategy to all selected databases; and (3) screening of reference lists of included primary articles for additional literature. Records were imported into EndNote 21 and deduplicated automatically and manually.

Source of evidence screening and selection

Screening was piloted on 25 records to calibrate the eligibility criteria. One reviewer screened all titles and abstracts. A second reviewer independently re-assessed all abstracts to verify eligibility decisions. Agreement at the abstract stage was 83.3% ($\kappa = 0.62$). Disagreements were resolved through discussion and reassessment until consensus was reached. A third reviewer was available to arbitrate, but no cases required escalation.

Full text articles were retrieved for all records deemed potentially eligible or ambiguous at abstract screening, and were assessed against the eligibility criteria by the primary reviewer. All full text decisions (inclusions, exclusions and ambiguous cases) were independently verified by the second reviewer, and reasons for exclusion were recorded (see Supplementary Table S1). Full text exclusions were categorized as follows: not focused on clinicians, not focused on international exchange, not about clinical practice/impact, not in child psychiatry/child mental health care, language not eligible, full text unavailable, or conference abstract only. Summary tables were used to produce record counts.

Data extraction

Data were extracted as reported in the included studies, and no data conversions or imputation were performed for missing summary statistics. Missing or unclear data were recorded as 'not reported', and the review focused on the information available in each study. Study decisions were tracked in a standardised Excel sheet with predefined drop-down codes for screening stage, reviewer decisions, and prespecified full text exclusion reasons. One reviewer extracted the data and a second reviewer verified all entries. The full data extraction form and coding framework are provided in Supplementary Appendix S3.

Eligibility was evaluated using the PCC framework (Population, Concept, Context), with the population defined as clinicians or trainees in CAMH services; the concept as cross-national clinical exchange; and the context as CAMH services providing care for children and adolescents aged 0–18 years (Munn et al., 2019). Cross-national exchanges of clinical knowledge and experience were defined as observerships, placements, in-person or virtual exchanges, or reciprocal visits focused on clinical practice.

Data were extracted on clinical outcomes (e.g., knowledge transfer, skills development in CAMH care) and professional development (e.g., perceived career impact). In addition to these outcomes, data were also extracted on study characteristics (e.g., design, sample size), participant characteristics (e.g., age, profession, experience), and funding sources. For studies that did not report funding sources, it was assumed that they were non-biased unless stated otherwise. Missing participant characteristics were recorded as not reported, and assumptions about the sample composition were made based on the descriptions in the methodology sections of the studies.

Critical appraisal of individual sources of evidence

Consistent with JBI guidance for scoping reviews, no formal critical appraisal of methodological quality was conducted. The purpose of this review was to map the existing literature rather than to evaluate study quality. No formal methods were employed to assess risk of bias due to missing results (reporting biases) or certainty or confidence in the body of evidence

for any outcome. The review focused on summarizing and mapping the findings from the included studies, rather than evaluating the methodological quality of individual studies.

Data analysis and presentation of results

This scoping review aimed to map existing research and did not use formal effect measures (e.g., risk ratio, mean difference). Given the heterogeneity of study designs, populations, and outcomes, a narrative synthesis was employed to summarize study characteristics and outcomes. Findings were synthesized narratively and summarized using descriptive counts. Studies were included based on their relevance to the review objectives, and the synthesis was guided by predefined eligibility criteria. No methods were employed to explore heterogeneity (e.g., subgroup analysis, meta-regression), and no sensitivity analyses were conducted, as the review focused on mapping literature rather than assessing the robustness of results. Results were summarized in tables and descriptive summaries, providing an overview of study characteristics, outcomes, and key findings.

Results

Study selection

PubMed, PsycINFO, and Web of Science databases were searched using a predefined search strategy. A PRISMA-style flow diagram summarises the selection process (See Figure 1). The search identified 2,244 records, of which 1,944 records remained after deduplication and were screened by title. Of these, 66 records proceeded to abstract screening, yielding 21 reports for full text retrieval. Three full texts articles were unavailable. The remaining 18 reports were assessed for eligibility, of which three studies met all criteria and were included. The other 15 reports were excluded because they did not focus on clinicians ($n = 8$), did not address cross-national clinical exchange ($n = 6$), or did not concern CAMH ($n = 1$). No further studies were excluded after meeting the inclusion criteria. An overview of full-text screening decisions and reasons for exclusion is provided in Supplementary Table S1.

Study characteristics

Overall, three studies described the effects of cross-national clinical exchange on clinical practice in CAMH ($n = 3$; see Table 1 for study details). The included articles were published between 2018 and 2024 and were conducted in the United States (US; $n = 1$), India ($n = 1$), and the Netherlands ($n = 1$).

Daoud et al. (2024) reported on an Indian-Tunisian exchange for two Tunisian early-career psychiatrists who participated in a clinical-academic exchange in an Indian medical institute. The study is a narrative account and did not report empirical data. The exchange consisted of a clinical observership, in-person and online academic exchanges, and community visits.

Figure 1: PRISMA 2020 flow diagram of the literature search and study selection.

Ibeziako et al. (2021) reported on a child mental health exchange programme hosted at a US medical institute involving twelve paediatricians, general psychiatrists and clinical psychologists from nine countries. The exchange consisted of an in-person clinical observership and academic exchange for a duration of 1–3 months. The study used a multi-method design combining quantitative and qualitative data.

de Veen et al. (2018) is a commentary that provides conceptual insights discussing the potential value of cross-national knowledge exchange between German and Dutch child and adolescent psychiatry. The editorial does not report empirical data.

As stated in the Methods section, no formal risk of bias assessments were conducted for the included studies, as the review aimed to map the existing literature rather than evaluate the methodological quality of individual studies.

Results of individual studies

Daoud et al. (2024) reported several observations from the Indian-Tunisian exchange. Participants noted differences in training structures: in Tunisia child and adolescent psychiatry is a separate five-year post-graduate training including one year of adult psychiatry training, whereas in India child and adolescent psychiatry training is part of a three-year general psychiatry programme with optional one-year fellowships. Participants also observed historically rooted differences in perinatal and child mental health care. The Indian model, historically influenced by British psychiatry, focuses on parental psychopathology and its impact on the child, while the Tunisian model, influenced by French psychiatry, emphasises parent–child interaction from a psychodynamic and developmental perspective. Despite these different roots, clinicians were perceived to use an eclectic approach in both settings, drawing from multiple frameworks. The exchange provided immersive clinical and cultural learning opportunities and practical exposure to adult and child psychiatric services. Participants described the experience as enriching and highlighted the value of cultural awareness, collaboration, and contextual adaptation in psychiatric practice. They also identified cross-context commonalities, including attitudes towards mental illness, stigma, and the societal role of traditional family structures, which they experienced as facilitating connection and informing ideas for future care and research collaboration. Challenges included language barriers, which were partly mitigated through translation. Demographic and economic differences also limited direct comparisons, even where participants perceived similarities in clinical practice and interdisciplinary collaboration. The authors concluded that, despite practical constraints, the combination of shared cultural and historical elements and cross-context differences identified during the exchange provide a good basis for future collaboration between the two countries.

Ibeziako et al. (2021) reported an exchange programme hosted in the US for paediatricians, general psychiatrists and clinical psychologists. Participant evaluations yielded consistently high ratings (mean scores 4.33–4.92 on a 5-point scale; see Supplementary Table S2 for domain-specific scores) across multiple domains, including perceived usefulness, satisfaction, self-reported knowledge gains, relevance to current and future work, and perceived facilitation of future networking and collaboration. Participants found the observership useful and relevant to their current and future work. They noted it improved their understanding of the US CAMH system, clinical approaches, and training and education models (e.g., undergraduate and postgraduate teaching, peer-to-peer workshops, and teacher training), as well as providing opportunities for networking and collaboration. Participants observed differences in clinical approach such as the high use of prescription medication. They valued the broad range of non-pharmacological treatments available and the high degree of specialisation in US services. Multidisciplinary collaboration was also viewed positively and highlighted as a strength of the host setting. However, participants also reported contextual and implementation challenges, including system-level constraints (e.g., insurance and reimbursement policies) and concerns about whether such multidisciplinary collaboration would be feasible in their own clinical contexts. Cultural factors, including differences in stigma, diagnostic patterns, and the influence of population diversity, were noted as important for understanding variations in clinical presentation and care delivery. At follow-up, participants reported that they had implemented a range of post-exchange efforts including contributions to workshops, training programmes and focus groups for health care providers, teachers, CAMH undergraduate and postgraduate courses and national awareness programmes. In addition, some participants reported advancement in leadership roles and career development, and grant acquisitions.

The editorial by de Veen et al. (2018) is a white paper presented as an editorial on the cross-national knowledge exchange in clinical practice and how it may improve CAP services using a German–Dutch comparison of child and adolescent psychiatry as an illustration. They compared epidemiological data on two common psychiatric conditions (autism spectrum disorder and affective disorders) and systematically explored factors that might explain differences in classification across countries. They argued that these differences were unlikely to reflect genetic variation, population-

First author (Year)	Country	Setting	Population group	Exchange type	Study design	Outcomes
Daoud (2024)	India	Clinical and academic	Psychiatrists	Observership/academic exchange	Descriptive account (no empirical data)	Reported learning across clinical and cultural contexts; enhanced understanding psychiatric practice in different cultural context; identification of cross-cultural challenges and opportunities for collaboration.
Ibeziako et al. (2021)	US	Clinical and academic	Psychiatrists, paediatricians, clinical psychologists	Observership/academic exchange	Multi-method (quantitative and qualitative)	High participant satisfaction; increased knowledge of CAMH systems and multidisciplinary care; post-exchange clinical, academic, and leadership productivity.
de Veen et al. (2018)	The Netherlands	No empirical setting; conceptual discussion	n.a. (editorial; no participants)	n.a. (editorial)	n.a. (editorial)	Conceptual reflections on cross-border collaboration in child psychiatry; no empirical outcomes reported.

Note. n.a. = not applicable. Outcomes represent the learning, observations, or impacts. The editorial presents conceptual reflections rather than empirical findings.

Table 1: Characteristics of included studies.

level symptom profiles, or training of health professionals. Rather, they suggested that the observed differences in administrative prevalence is likely related to differences in health care system organisation (e.g., in versus outpatient clinics, referral patterns and sub-specialisation) and cultural factors. The authors also describe preliminary findings from clinical exchanges showing divergent diagnostic tendencies between German and Dutch clinicians. Results showed a difference in diagnostic tendencies at the level of individual patients. This was especially the case in patients with autism spectrum disorder and affective disorder symptoms with Dutch experts more frequently endorsing the diagnosis of autism spectrum disorder than the German professionals (and vice versa for affective disorders). Considering that in both regions

professionals are highly trained and experienced, this discrepancy in assessment is most likely to be explained by differences in culture or child and adolescent psychiatric care provision.

Thematic synthesis

Across the three included reports, four overarching themes emerged that focus on both clinical content and organisational context: (1) awareness of cross-national differences and commonalities in clinical practice; (2) mental health care system factors shaping service delivery and care organisation; (3) cultural factors shaping mental health care systems and clinical practice; and (4) the value and impact of cross-national clinical exchange. Each theme is described in more detail below:

Theme 1: Awareness of cross-national differences and commonalities in clinical practice

The three included reports described notable differences and commonalities in clinical practice and the organisational context in which care was delivered between countries. Shared diagnostic systems (e.g. ICD/DSM) provided a common language across countries, enabling clinicians to recognise diagnoses, understand each other's terminology, and compare approaches. Reported differences included referral patterns and pathways into care, diagnostic assessment routines, and contextual and system features such as the structure of clinical settings and services. Differences were also noted in treatment, including treatment strategies (e.g. use of pharmacotherapy), the availability and organisation of treatment options, and multidisciplinary approaches to CAMH care.

Theme 2: Mental health care system factors shaping service delivery and care organisation

Mental health care system characteristics influencing service delivery and care organisation were described across all reports. The India-Tunisia and US reports noted that multidisciplinary collaboration and the degree of programme specialisation can differ between countries, influencing the types of care available and how services are organised. In the US study, participants also reflected on differences in insurance and reimbursement systems and how these shaped access to and delivery of mental health care. The German-Dutch commentary highlighted how variations in reimbursement structures, mental health care network, referral patterns, and service models (e.g., inpatient vs. outpatient care) contribute to differences in clinical practices and the patient populations seen in child and adolescent psychiatric clinics.

Theme 3: Cultural factors shaping mental health care systems and clinical practice

Across all three reports, culture was described as an overarching context shaping both the mental health care system and routine clinical practice. The India-Tunisia study noted that perspectives on diagnosis and treatment may differ between countries due to historical and cultural influences. In the US study, an observer with a similar cultural background to the patient was able to offer additional insights during a case discussion, illustrating how cultural perspectives can enrich clinical understanding. Cultural influences also emerged in relation to stigma regarding mental health problems, cultural expressions of mental health problems, and gender and family norms relevant to clinical practice. Across studies, cultural context was highlighted as an important factor shaping how clinicians understand, categorise, and respond to CAMH needs.

Theme 4: Value and impact of cross-national clinical exchange

All included reports described clear added value for professionals participating in cross-national clinical exchanges. Participants reported gaining new perspectives on diagnostic assessment, treatment approaches, and academic work. Across reports, clinicians noted that observing alternative approaches to CAMH care prompted reflection on their own practice and shaped how they thought about care delivery. The US study also highlighted the academic output and career development of professionals following participation. The India-Tunisia and US studies both described increased motivation and opportunities for continued cross-national collaboration.

Biases and certainty of evidence

Study characteristics and findings were summarised qualitatively using a narrative synthesis. As this was a scoping review mapping the literature rather than evaluate study quality or intervention effects, we did not assess risk-of-bias, reporting biases, or rate certainty or confidence in the body of evidence. We also did not conduct statistical synthesis or a meta-analysis, heterogeneity analyses (e.g., subgroup analyses), or sensitivity analyses because of heterogeneity in study designs, populations, and outcomes.

Discussion

This scoping review aimed to map the effects of cross-national clinical exchange in child and adolescent psychiatry, including reported benefits, challenges, and impact on clinical practice. Evidence was limited: only three studies met the eligibility criteria, of which one reported qualitative and quantitative findings and two were more anecdotal evaluations. As such, findings should be interpreted cautiously and mainly as an initial mapping of reported experiences and contextual factors. Across these three reports, each using a different approach, four overarching themes could be identified: cross-national differences and commonalities in clinical practice; mental health care system characteristics shaping how care is organised; cultural influences on clinical practice; and perceived added value of cross-national clinical exchange for clinical practice.

Across reports, the perceived value of cross-national exchanges seemed to come from exposure to different clinical practices, mental health care systems and cultural norms. This helped professionals compare new approaches with their own work setting and initiate reflection. As a result, assumptions about what participants to cross-national exchanges previously considered to be 'standard' care practices and policies were re-examined. In addition to learning from different clinical approaches, one report also described effects on academic output, career development, and greater motivation to collaborate. This is in line with Experiential Learning Theory, which emphasises learning may start with sometimes unexpected experience, followed by reflection, conceptualisation, and application (Kolb et al., 2014). When participants observe differences, they can reflect on why these occur. For example, treatment choices and assessment routines may reflect local guidelines, service availability, reimbursement rules, and workforce capacity, referral structures, and the degree of support for multidisciplinary care. Once participants realise this distinction, they can conceptualise and form new expectations about what can be adapted within existing services (e.g., revising protocols and routines) and what would require system-level change (e.g., reimbursement arrangements). As such, perspective expansion may be an important first step for individual learning and change within a system. Of course, not all steps of the learning cycle are always fulfilled and learning and reflection do not necessarily mean that observed practices will be directly transferred to the home setting.

Across the included reports, cultural context was presented as relevant for understanding differences in clinical practice, but it was rarely described as a single, clearly defined influence. Instead, culture appeared in how distress was recognised, how symptoms and family dynamics were interpreted, and what kinds of help were viewed as acceptable. Culture was also discussed in relation to stigma, gender, and family norms. Regardless of the precise definition, all of these references to cultural factors may shape expectations about responsibility for care and the roles of families and professionals, with implications for everyday practice and service organisation. The limited experiences with cross-national clinical exchange add to the ongoing debate on whether psychiatric diagnoses are largely universal, with culture shaping symptom expression and diagnostic thresholds, or culturally relative, with culture influencing what counts as disorder and how symptoms cluster (Canino & Alegría, 2008). Further experiences of cross-national exchange could be supportive of a view proposed almost 25 years ago: that some conditions that may be relatively stable across cultures, whereas others may depend more on social context, cultural norms, and developmental expectations (Rutter & Nikapota, 2002). Taken together, this suggests that cross-national exchanges involve not only comparing routines or service models, but also making explicit which observed differences are likely to be transferable to other settings and which are primarily context-specific.

Cross-national exchange programmes depend on a shared language that allows clinicians to communicate and exchange ideas. This is important at two levels: a common working language, often English, and shared professional terminology. Classification systems such as DSM-5 and ICD-11 can provide a clinical language that enables clinicians to discuss similar problems using comparable terms. However, shared classification terminology does not necessarily imply identical diagnostic practices, as the interpretation and application of categories may still vary across settings due to cultural norms and care system factors. Even when clinicians share a working language and diagnostic terminology, transferring or adapting practices observed during exchanges in the host setting to clinicians' home context may be challenging. For example, multidisciplinary care was viewed as helpful for addressing complex needs, but it often depends on resources, staffing, and infrastructure that support specialisation in child and adolescent mental health care. As a result, what can realistically be adopted in clinical practice may still depend on cultural norms and the local mental health care system.

Although evidence specific to child and adolescent psychiatry was scarce, the results resonate with the broader literature on exchange in general psychiatry. A recent report on the World Psychiatry Exchange Program describes learning through observation in different clinical and cultural settings, with reported gains in knowledge, skills, international networks, inclusivity and equality within the system as a whole (Pinto da Costa et al., 2025). In adjacent work that compares training and practice across countries, rather than evaluating exchange placements, differences are likewise presented as reflecting system structures and professional norms, and authors often propose structured student and faculty exchanges as one mechanism to support mutual learning and mobility (Fonzi et al., 2020).

This scoping review has some limitations. First, data extraction and title screening were conducted by a single reviewer which may increase the risk of selection or extraction bias. To mitigate this, all abstract screening decisions and extracted data were independently verified by a second reviewer using a standardised form. Second, only three eligible studies were identified, of which two were anecdotal reports. This limits the robustness of the evidence that could be mapped. To aid interpretation, we conducted a brief, non-systematic scan of adjacent literature on international clinical exchanges in psychiatry. In addition, as this review aimed to map the literature, we did not assess risk of bias, reporting biases, or certainty of evidence, nor undertake statistical synthesis (e.g. meta-analysis, heterogeneity or sensitivity analyses), so findings should be interpreted as descriptive rather than as evidence of effects or robustness. The small number of studies we could identify may partly be explained by the narrow focus on child and adolescent mental health care. Future research could shed light on the specificity of exchange programmes by comparing the effects in related areas including e.g., general psychiatry or paediatrics. which may mean relevant insights from adjacent fields were not captured. Finally, one included report was authored by a review team member. It was included because it met prespecified eligibility criteria, and extraction and synthesis were independently verified to mitigate potential bias.

Conclusion

We identified three eligible publications on cross-national clinical exchange in child and adolescent psychiatry, of which one reported empirical findings and two were anecdotal reports. Despite the scarcity of empirical studies, the present review of the literature suggests that cross-national exchange programmes may provide a unique learning experience for clinicians helping them reflect on their own clinical practice, including the influence of their local system of care and culture. Future research should prioritise prospective, real-world evaluations of cross-national clinical exchanges, assessing feasibility, costs, and impact on clinical practice to inform policy decisions around the integration of such exchanges into mental health care systems. Evaluations should also examine cultural processes within exchanges, including how participants define cultural differences and how these shape clinical reasoning, communication, and perceptions of what care is feasible or appropriate. Living-lab approaches may offer a practical way to organise and sustain cross-national exchanges, for example in neighbouring regions where cross-national collaboration is already feasible. Qualitative research alongside these evaluations is also needed to understand how exchanges may improve care and in which settings they are most effective. Finally, once a larger research basis exists, a systematic review of

effectiveness and cost-benefit may become feasible and could provide more conclusive evidence on whether cross-national clinical exchange improves care in child and adolescent psychiatry.

Abbreviations

- CAMH

Child and adolescent mental health

- CAP

Child and adolescent psychiatry

- DSM-5

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

- ICD-11

International Classification of Diseases, 11th Revision

- JBI

Joanna Briggs Institute

- OSF

Open Science Framework

- PCC

Population, Concept, Context

- PRISMA-ScR

Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews

Declarations

Ethics approval and consent to participate

Ethical approval was not required for this scoping review, as it involved the analysis of previously published literature and did not include the collection of primary data from human participants.

Consent for publication

Not applicable.

Availability of data and materials

The review was conducted in accordance with established methodological guidance for scoping reviews. The data, code, and other materials used in this review are publicly available and can be accessed at <https://osf.io/y69qw/> . This includes the template data collection forms, the extracted data from the included studies, the data used for analyses, and the search query.

Competing interests

The authors declare that they have no conflicts of interest.

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Authors' contributions

Bas de Veen (BdV) was responsible for conceptualisation and protocol development, data collection, data curation, and drafting of the manuscript. BdV and Katrin Bringmann (KB) jointly conducted the data analysis; KB verified records and provided critical feedback on the manuscript. Pierre Herpers (PH), Martine van Dongen-Boomsma (MvDB), Wouter Staal (WS), Ron Scholte (RS), and Peter Deschamps (PD) contributed to the design of the research and offered critical revisions to the manuscript.

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Authors' information

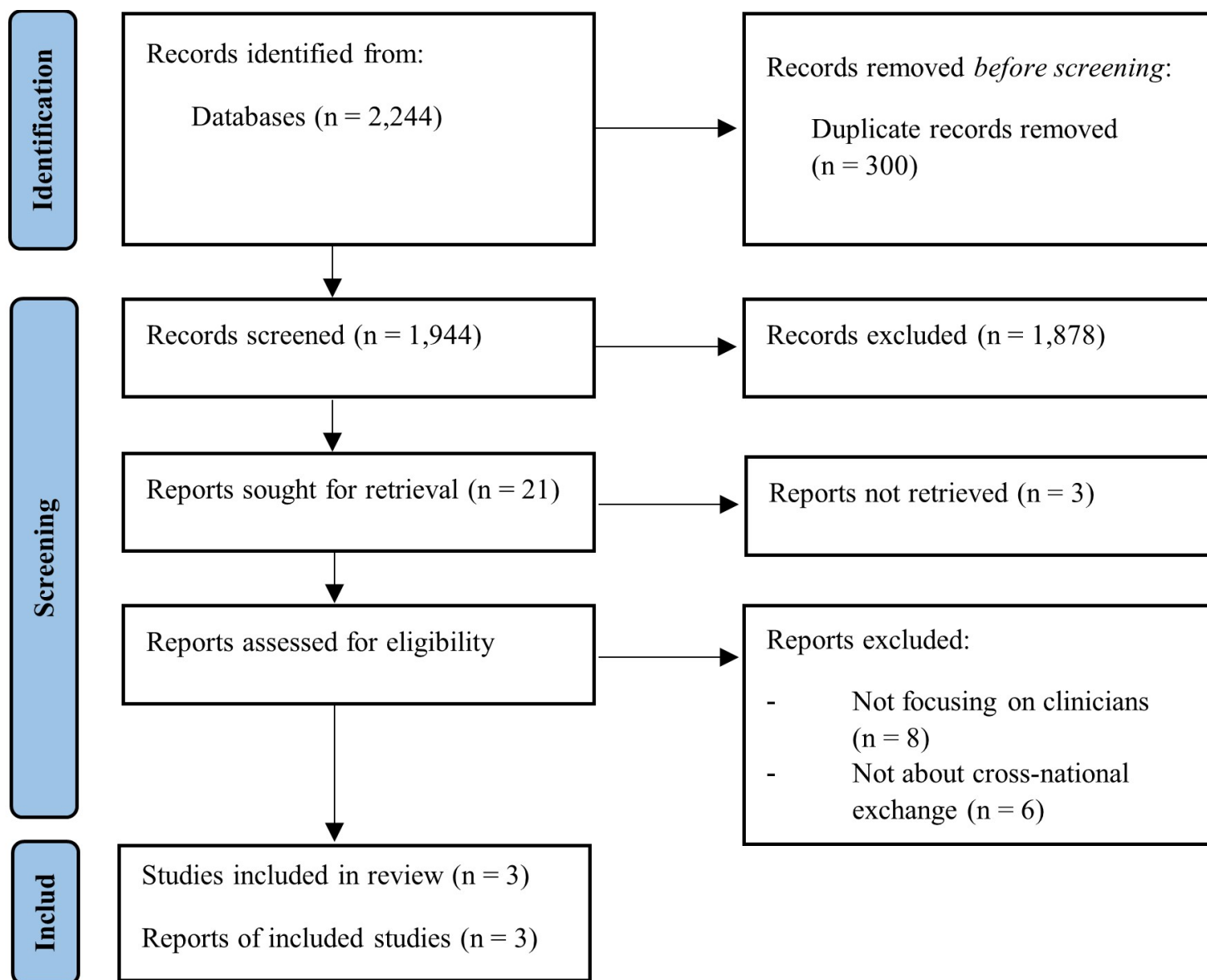
The author team has experience with Dutch–German cross-border collaborations in child and adolescent psychiatry. This background reflects a commitment to sharing knowledge across countries and mental health care systems. By combining perspectives from psychiatry, psychology, and behavioural science, the team aims to emphasise the value of professional and cross-national diversity in improving mental health care for young people.

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Figures



Note. Adapted from Page et al. (2021).

Figure 1

PRISMA 2020 flow diagram of the literature search and study selection.

Supplementary Files

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- [SupplementaryAppendixS3Dataextractiontemplate.xlsx](#)
- [SupplementaryChecklistS2PRISMA2020checklist.docx](#)
- [SupplementaryChecklistS1PRISMA2020abstractchecklist.docx](#)
- [SupplementaryTableS1.docx](#)
- [SupplementaryTableS2.docx](#)
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